

		FOR OHF USE					

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**2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)**

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0036798</u> Facility Name: <u>Rosewood Care Center-Joliet</u> Address: <u>3401 Hennepin Drive</u> <u>Joliet</u> <u>60435</u> <div style="display: flex; justify-content: space-between; width: 100%;"> Number City Zip Code </div> County: <u>Will</u> Telephone Number: <u>(815) 436-5900</u> Fax # <u>()</u> IDPA ID Number: <u>431478199001</u> Date of Initial License for Current Owners: <u>01/31/91</u> Type of Ownership: <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____ </div> <div> <input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </div> <div> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </div> </div>	
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In the event there are further questions about this report, please contact:
Name: Cindy A. Tefteller **Telephone Number:** (618) 465-7717

SEE ACCOUNTANTS' COMPILATION REPORT

DPA 3745 (N-4-99)

IL478-2471

Print Preview

Facility Name & ID Number Rosewood Care Center-Joliet# 0036798Report Period Beginning: 07/01/1999 Ending: 06/30/2000

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>120</u>	Skilled (SNF)	<u>120</u>	<u>43,920</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>120</u>	TOTALS	<u>120</u>	<u>43,920</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF			<u>12,367</u>	<u>12,367</u>	8
9	SNF/PED					9
10	ICF	<u>2,991</u>	<u>22,641</u>		<u>25,632</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>2,991</u>	<u>22,641</u>	<u>12,367</u>	<u>37,999</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4 86.52%)

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)NoneF. Does the facility maintain a daily midnight census? YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 01/31/91

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date 01/31/91 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number
of beds certified 46 and days of care provided 12367Medicare Intermediary Tri-Span

IV. ACCOUNTING BASIS

MODIFIED
ACCRUAL ☒ CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 06/30/2000 Fiscal Year: 06/30/2000

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

STATE OF ILLINOIS

Page 3

Facility Name & ID Number Rosewood Care Center-Joliet # 0036798 Report Period Beginning: 07/01/1999 Ending: 06/30/2000
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	190,742	21,479	11,896	224,117		224,117	0	224,117		1
2	Food Purchase		162,486		162,486		162,486	(5,622)	156,864		2
3	Housekeeping	121,526	21,644		143,170		143,170	0	143,170		3
4	Laundry	36,587	10,082		46,669		46,669	0	46,669		4
5	Heat and Other Utilities			100,487	100,487		100,487	0	100,487		5
6	Maintenance	23,118	8,935	57,554	89,607		89,607	5,683	95,290		6
7	Other (specify): Sanitation			20,489	20,489		20,489	0	20,489		7
8	TOTAL General Services	371,973	224,626	190,426	787,025		787,025	61	787,086		8
	B. Health Care and Programs										
9	Medical Director			12,575	12,575		12,575	0	12,575		9
10	Nursing and Medical Records	1,831,451	212,771	66,163	2,110,385		2,110,385	0	2,110,385		10
10a	Therapy	74,134	8,545	677,801	760,480		760,480	45,695	806,175		10a
11	Activities	49,002	5,059	536	54,597		54,597	0	54,597		11
12	Social Services	43,612	48	2,449	46,109		46,109	0	46,109		12
13	Nurse Aide Training							0			13
14	Program Transportation							0			14
15	Other (specify):*							0			15
16	TOTAL Health Care and Progra	1,998,199	226,423	759,524	2,984,146		2,984,146	45,695	3,029,841		16
	C. General Administration										
17	Administrative			875,125	875,125		875,125	(735,310)	139,815		17
18	Directors Fees							0			18
19	Professional Services			4,875	4,875		4,875	66,359	71,234		19
20	Dues, Fees, Subscriptions & Promotions			33,702	33,702		33,702	(9,565)	24,137		20
21	Clerical & General Office Expense	156,661	25,370	29,414	211,445		211,445	219,882	431,327		21
22	Employee Benefits & Payroll Taxes			362,535	362,535		362,535	35,076	397,611		22
23	Inservice Training & Education							0			23
24	Travel and Seminar			1,934	1,934		1,934	(113)	1,821		24
25	Other Admin. Staff Transportation			6,218	6,218		6,218	34,456	40,674		25
26	Insurance-Prop.Liab.Malpractice			29,049	29,049		29,049	4,718	33,767		26
27	Other (specify):*							0			27
28	TOTAL General Administration	156,661	25,370	1,342,852	1,524,883		1,524,883	(384,497)	1,140,386		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,526,833	476,419	2,292,802	5,296,054		5,296,054	(338,741)	4,957,313		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000. SEE ACCOUNTANTS' COMPILATION REPORT
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Print Preview

IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

STATE OF ILLINOIS

Page 4

Facility Name & ID Number Rosewood Care Center-Joliet

0036798

Report Period Beginning: 07/01/1999 Ending: 06/30/2000

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			10,548	10,548		10,548	247,042	257,590		30
31	Amortization of Pre-Op. & Org.							18,036	18,036		31
32	Interest			31,418	31,418		31,418	634,495	665,913		32
33	Real Estate Taxes			85,717	85,717		85,717	0	85,717		33
34	Rent-Facility & Grounds			1,373,383	1,373,383		1,373,383	(1,360,315)	13,068		34
35	Rent-Equipment & Vehicles							0			35
36	Other (specify):*							0			36
37	TOTAL Ownership			1,501,066	1,501,066		1,501,066	(460,742)	1,040,324		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation							0			38
39	Ancillary Service Centers		166,926	31,286	198,212		198,212	(321)	197,891		39
40	Barber and Beauty Shops			15,892	15,892		15,892	0	15,892		40
41	Coffee and Gift Shops							0			41
42	Provider Participation Fee			65,880	65,880		65,880	0	65,880		42
43	Other (specify):*							0			43
44	TOTAL Special Cost Centers		166,926	113,058	279,984		279,984	(321)	279,663		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,526,833	643,345	3,906,926	7,077,104	0	7,077,104	(799,804)	6,277,300		45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Print Preview

SEE ACCOUNTANTS' COMPILATION REPORT

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

STATE OF ILLINOIS

Page 5

Facility Name & ID Number **Rosewood Care Center-Joliet**

0036798

Report Period Beginning: **07/01/1999**

Ending: **6/30/2000**

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1 Amount	2 Refer- ence	3 OHF USE ONLY	
	NON-ALLOWABLE EXPENSES				
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Program:				3
4	Non-Patient Meals	(5,143)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(321)	39		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(479)	2		13
14	Non-Care Related Interest	(31,418)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(3,000)	20		17
18	Fines and Penalties				18
19	Entertainment	(113)	24		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(1,930)	20		25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(4,635)	20		28
29	Other-Attach Schedule <u>Marketing Salary</u>	(59,791)	21		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (106,830)		\$	30

OHF USE ONLY							
48		49		50		51	52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below. (See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(692,974)	Var	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (692,974)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (799,804)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference
38	Medically Necessary Transport		X	\$	38
39					39
40	Gift and Coffee Shops		X		40
41	Barber and Beauty Shops		X		41
42	Laboratory and Radiology		X		42
43	Prescription Drugs		X		43
44	Exceptional Care Program		X		44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$	47

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.

IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Summary A

Facility Name & ID Numb Rosewood Care Center-Joliet

0036798 Report Period Beginning:

07/01/1999

Ending: 06/30/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary

Summary		Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
		A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(5,622)	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	5,683	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(5,622)	0	5,683	0	0	0	0	0	0	0	0	0	8
B. Health Care and Programs														
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	45,695	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Program	0	45,695	0	0	0	0	0	0	0	0	0	0	16
C. General Administration														
17	Administrative	0	(855,125)	119,815	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	102	66,257	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(9,565)	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(59,791)	1,624	278,049	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	290	34,786	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(113)	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	34,456	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	4,718	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(69,469)	(853,109)	538,081	0	0	0	0	0	0	0	0	0	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(75,091)	(807,414)	543,764	0	0	0	0	0	0	0	0	0	29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

STATE OF ILLINOIS

Summary B

Facility Name & ID Numb Rosewood Care Center-Joliet# 0036798

Report Period Beginning:

07/01/1999 Ending:

06/30/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

mary	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	(to Sch V, col.7)
30	Depreciation	0	222,261	24,781	0	0	0	0	0	0	0	0	247,042	30
31	Amortization of Pre-Op. & Org.	0	18,036	0	0	0	0	0	0	0	0	0	18,036	31
32	Interest	(31,418)	665,913	0	0	0	0	0	0	0	0	0	634,495	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	#####	13,068	0	0	0	0	0	0	0	0	(1,360,315)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(31,418)	(467,173)	37,849	0	0	0	0	0	0	0	0	(460,742)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	(321)	0	0	0	0	0	0	0	0	0	0	(321)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Cent	(321)	0	0	0	0	0	0	0	0	0	0	(321)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(106,830)	#####	581,613	0	0	0	0	0	0	0	0	(799,804)	45

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	17 See Schedule VIII	\$	HSM Management Services, Inc.	100.00%	\$ 119,815	\$ 119,815
16	V	21 See Schedule VIII		HSM Management Services, Inc.	100.00%	278,049	278,049
17	V	22 See Schedule VIII		HSM Management Services, Inc.	100.00%	34,786	34,786
18	V	25 See Schedule VIII		HSM Management Services, Inc.	100.00%	34,456	34,456
19	V	30 See Schedule VIII		HSM Management Services, Inc.	100.00%	24,781	24,781
20	V	34 See Schedule VIII		HSM Management Services, Inc.	100.00%	13,068	13,068
21	V	19 See Schedule VIII		HSM Management Services, Inc.	100.00%	66,257	66,257
22	V	26 See Schedule VIII		HSM Management Services, Inc.	100.00%	4,718	4,718
23	V	6 See Schedule VIII		HSM Management Services, Inc.	100.00%	5,683	5,683
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 581,613	\$ * 581,613

Sum_6A

119815
278049
34786
34456
24781
13068
66257
4718
5683

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V		\$			\$	\$
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$	\$ *

Sum_6B

* Total must agree with the amount recorded on line 34 of Schedule VI. SEE ACCOUNTANTS' COMPILATION REPORT

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Page 6C

Facility Name & ID Number Rosewood Care Center-Joliet

0036798

Report Period Beginn 07/01/1999 Ending: 06/30/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V		\$			\$	\$
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$	\$ *

Sum_6C

* Total must agree with the amount recorded on line 34 of Schedule VI. SEE ACCOUNTANTS' COMPILATION REPORT

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V		\$			\$	\$
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$	\$ *

Sum_6D

* Total must agree with the amount recorded on line 34 of Schedule VI. SEE ACCOUNTANTS' COMPILATION REPORT

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Larry Vander Maten	President	Management	75.00%	436,780	4	8.22%	Salary	\$ 33,032	17-8	1
2	Darrell Hoefling	Vice-President	Management	25.00%	156,260	4	8.22%	Salary	15,011	17-8	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 48,043		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORT

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

| the name(s)
PORTS.

Facility Name & ID Number Rosewood Care Center-Joliet# 0036798 Report Period Beginning: 07/01/1999Ending: 5/30/2000

VIII. ALLOCATION OF INDIRECT COSTS

Show Pgs 8A thru 8

Show Pgs 8E thru 8

Hide Pgs 8A thru 8

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization HSM Management Services, Inc.Street Address 11701 Borman Drive, Suite 315City / State / Zip Code St. Louis, MO 63146Phone Number (314) 994-9070Fax Number (314) 994-9912

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	Salaries - Officers	Total Cost	17	\$ 341,083	\$ 341,083	5,206,757	\$ 28,043	1
2	21	Salaries - Other	Total Cost	17	2,916,125	2,916,125	5,206,757	239,760	2
3	22	Payroll Taxes	Total Cost	17	221,266		5,206,757	18,192	3
4	22	Employee Benefits	Total Cost	17	87,376		5,206,757	7,184	4
5	25	Travel	Total Cost	17	123,502		5,206,757	10,154	5
6	30	Depreciation	Total Cost	17	273,812		5,206,757	22,513	6
7	34	Building Rent	Total Cost	17	158,940		5,206,757	13,068	7
8	19	Professional Services	Total Cost	17	805,860		5,206,757	66,257	8
9	21	Telephone	Total Cost	17	167,133		5,206,757	13,741	9
10	26	Insurance	Total Cost	17	57,385		5,206,757	4,718	10
11	21	Taxes & Licenses	Total Cost	17	7,008		5,206,757	576	11
12	21	Office Supplies	Total Cost	17	291,559		5,206,757	23,972	12
13	6	Maintenance	Total Cost	17	46,996		5,206,757	3,864	13
14	17	Direct - Admin	Direct Cost	1	91,772	91,772	1	91,772	14
15	17	Direct - Admin	Direct Cost	16	876,781	876,781	0	0	15
16	22	Direct - Payroll Taxes	Direct Cost	1	9,410		1	9,410	16
17	22	Direct - Payroll Taxes	Direct Cost	16	88,767		0	0	17
18	30	Direct - Depreciation	Direct Cost	1	2,268		1	2,268	18
19	30	Direct - Depreciation	Direct Cost	16	30,242		0	0	19
20	25	Direct - Travel	Direct Cost	1	24,302		1	24,302	20
21	25	Direct - Travel	Direct Cost	16	209,497		0	0	21
22	6	Direct - Maintenance	Direct Cost	1	1,819		1	1,819	22
23	6	Direct - Maintenance	Direct Cost	16	6,610		0	0	23
24									24
25	TOTALS				\$ 6,839,513	\$ 4,225,761		\$ 581,613	25

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Nations Bank		X	Mortgage	Varies	03/99	\$ 9,789,265	\$ 9,497,833	03/2006	PRM+1/2	\$ 698,497	1	
2	Less: Related Party Interest Income										(32,584)	2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 9,789,265	\$ 9,497,833			\$ 665,913	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 9,789,265	\$ 9,497,833			\$ 665,913	15	

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

Facility Name & ID Number Rosewood Care Center-Joliet# 0036798 Report Period Beginning: 07/01/1999 Ending: 06/30/2000**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 1999 report.	\$	<u>84,700</u>	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	<u>84,217</u>	2
3. Under or (over) accrual (line 2 minus line 1).	\$	<u>(483)</u>	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	<u>86,200</u>	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	\$	<u>85,717</u>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1995	1996	1997	1998	1999
	<u>86,851</u>	<u>91,326</u>	<u>86,644</u>	<u>84,379</u>	<u>84,056</u>
	8	9	10	11	12

1998 Payment \$42,189

1999 Payment \$42,028

Accrual = Remaining 1999 (42,027) + 1/2 of estimated 2000 tax bill (44,173)

FOR OFF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 1999	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATIC	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 39,200 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? ☐ (a) Own the Facility ☒ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☐ (a) Own the Equipment ☒ (b) Rent equipment from a Related Organization. ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☒ YES ☐ NO

If so, please complete the following:

1. Total Amount Incurred: \$22,724 2. Number of Years Over Which it is Being Amortized: Org. Costs and Loan Fees - 60 Mos.

3. Current Period Amortization: 18,036 4. Dates Incurred: 8/93 for Prior Mortgage; 6/96 Refinancing

Nature of Costs: Loan Refinanced 1995; All prior loan related costs were expensed. Refin. Costs - \$22,724

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Nursing Home</u>	<u>39,200</u>	<u>1990</u>	<u>\$ 230,225</u>	1
2					2
3	TOTALS	39,200		\$ 230,225	3

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12

Show Pgs 12C and 12

Hide Pgs 12A thru 12

STATE OF ILLINOIS

Page 12

Facility Name & ID Number Rosewood Care Center-Joliet

0036798

Report Period Beginning:

07/01/1995 Ending: 06/30/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	120			1990	\$ 3,475,917	\$	25	\$ 139,037	\$ 139,037	\$ 1,390,370	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	General Requirements			1991	25,516		25	1,021	1,021	9,700	9
10	Developer Fee			1991	28,980		25	1,159	1,159	11,011	10
11	Construction Period Interest			1991	20,364		25	815	815	7,743	11
12	Arch and Eng Fees			1991	4,459		25	178	178	1,691	12
13	Storm Sewer			1991	32,675		25	1,307	1,307	12,417	13
14	Lawn Sprinkler			1991	10,990		25	440	440	4,180	14
15	Landscaping			1991	55,127		25	2,205	2,205	20,948	15
16	Mass Grading			1991	54,747		25	2,190	2,190	20,805	16
17	Asphalt Paving			1991	48,390		25	1,936	1,936	18,392	17
18	Sanitary Sewer			1991	8,069		25	323	323	3,069	18
19	Water Line			1991	15,500		25	620	620	5,890	19
20	Driveway and Sidewalks			1991	55,932		25	2,237	2,237	21,252	20
21	Walk-In Cooler Refrigerator			1991	6,888		20	344	344	3,268	21
22	Sink			1991	2,049		10	205	205	1,948	22
23	Exhaust and Air Hood			1991	4,670		10	467	467	4,437	23
24	Fire Exting. System			1991	1,647		10	165	165	1,568	24
25	Combo. Range/Hood			1991	3,925		10	393	393	3,734	25
26	Building Signage			1991	7,300		10-15	578	578	5,492	26
27	Generator/Accessories			1991	15,764		20	788	788	7,486	27
28	Cubicle Curtain Track			1991	6,176		10	618	618	5,871	28
29	6 Stainless Doors			1991	2,685		10	269	269	2,556	29
30	Monument Sign			1991	3,193		10	319	319	3,031	30
31	Wallcovering			1991	19,849		10	1,985	1,985	18,858	31
32	Carpeting			1991	9,585		10	959	959	9,111	32
33	Nurse Call System			1991	28,217		20	1,411	1,411	13,405	33
34	Fire Alarm System			1991	15,724		20	786	786	7,467	34
35	Continued on Next Page										35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				\$ #VALUE!	\$		\$ 162,755	\$ 162,755	\$ 1,615,700	36

*Total beds on this schedule must agree with page 2.

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE
REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12

STATE OF ILLINOIS

Page 12A

Facility Name & ID Numbe Rosewood Care Center-Joliet

0036798

Report Period Beginning:

07/01/1995 Ending: 06/30/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	Door Bell			1991	1,026		20	51	51	485	9
10	Door Alarm			1991	5,773		20	289	289	2,746	10
11	Public Address			1991	5,022		20	251	251	2,385	11
12	Cable			1991	15,712		20	786	786	7,467	12
13	Hot Water Boiler			1991	6,792		10	679	679	6,451	13
14	Hot Water Heater			1991	7,841		10	784	784	7,448	14
15	Load Bank Generator			1997	3,945		10	395	395	1,317	15
16	Leasehold Improvements - Facility										16
17	Painting/Baseboards/Tiling			1995	14,902	2,128	7	2,128		11,584	17
18	Carpeting			1996	4,157	594	7	594		2,651	18
19	Floor Drain			1997	1,604	229	7	229		611	19
20	Entry Floor Mat			1999	1,213	173	7	173		231	20
21	Ceiling Tiles			1999	1,820	260	7	260		325	21
22	Plants			1999	2,441	349	7	349		407	22
23	Wallpaper/Wallpaper Install/Blinds			1999	14,251	2,036	7	2,036		2,682	23
24	Air System			1999	13,860	1,980	7	1,980		2,145	24
25	Bedspreads			1999	8,869	1,267	7	1,267		1,267	25
26	Carpeting			1999	14,300	1,532	7	1,532		1,532	26
27	Leasehold Improvements - Management Company										27
28	Office Construction/Improvements			1995	629		5	126	126	629	28
29	Office Design			1995	58		5	12	12	58	29
30	Office Shelving			1996	134		4	32	32	134	30
31	Office Expansion			1996	594		4	149	149	594	31
32	Office Expansion			1997	1,591		3	505	505	1,591	32
33	Office Expansion			1998	898		3	300	300	532	33
34	Office Addition			1999	443		3	148	148	148	34
35	Door Locks			1999	221		3	43	43	43	35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				\$ #VALUE!	\$ 10,548		\$ 15,098	\$ 4,550	\$ 55,463	36

*Total beds on this schedule must agree with page 2.

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

**IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE
REMOVE THE TEXT FROM COLUMN 2 OR 3.**

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STATE OF ILLINOIS

Page 12B

Facility Name & ID Number Rosewood Care Center-Joliet

0036798

Report Period Beginning: 07/01/1995 Ending: 06/30/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				\$ #VALUE!	\$		\$	\$	\$	36

*Total beds on this schedule must agree with page 2.

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

Facility Name & ID Number Rosewood Care Center-Joliet# 0036798Report Period Beginning: 07/01/1999 Ending: 06/30/2000**XI. OWNERSHIP COSTS (continued)****C. Equipment Depreciation-Excluding Transportation. (See instructions.)**

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Componer Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$ 719,478	\$	\$ 68,395	\$ 68,395	5-7 Yrs	\$ 582,030	37
38	Current Year Purchases	22,784		1,433	1,433	5-7 Yrs	1,433	38
39	Fully Depreciated Assets	913					913	39
40								40
41	TOTALS	\$ 743,175	\$	\$ 69,828	\$ 69,828		\$ 584,376	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	HSM Management	Various	Various	\$ 57,884	\$	\$ 9,909	\$ 9,909	5 Yrs	\$ 23,084	42
43										43
44										44
45										45
46	TOTALS			\$ 57,884	\$	\$ 9,909	\$ 9,909		\$ 23,084	46

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ #VALUE!	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 10,548	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 257,590	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ 247,042	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 2,278,623	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	Section Not Applicable	\$	\$	\$	52
53					53
54					54
55					55
56					56
57	TOTALS	\$	\$	\$	57

G. Construction-in-Progress

	Description	Cost	
58	Section Not Applicable	\$	58
59			59
60			60
61		\$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

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XII. RENTAL COSTS**A. Building and Fixed Equipment (See instructions.)**1. Name of Party Holding Lease Schedule Not Applicable

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34. _____

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.9. Option to Buy: ☐ YES ☐ NO Terms: _____ ***B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO16. Rental Amount for movable equipment \$ _____ Description: _____
(Attach a schedule detailing the breakdown of movable equipment)**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2001 \$ _____13. /2002 \$ _____14. /2003 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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Facility Name & ID Number Rosewood Care Center-Joliet # 0036798 Report Period Beginning: 07/01/1999 Ending: 06/30/2000

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>SCHEDULE NOT APPLICABLE - ONLY HIRE CERTIFIED AIDES</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
---	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.
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Facility Name & ID Number Rosewood Care Center-Joliet# 0036798 Report Period Beginning: 07/01/1999 Ending: 06/30/2000

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a-8	hrs	\$	28,363	\$ 262,853	\$	28,363	\$ 262,853	1
2	Licensed Speech and Language Development Therapist	10a-8	hrs		2,301	39,261		2,301	39,261	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-8	hrs		31,585	421,382	8,545	31,585	429,927	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-8	# of prescripts				166,926		166,926	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Ambulance, Specialty Beds, X-Ray & Other (specify): Lab Fees	39-8				30,965			30,965	13
14	TOTAL			\$	62,249	\$ 754,461	\$ 175,471	62,249	\$ 929,932	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

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STATE OF ILLINOIS

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Facility Name & ID Number Rosewood Care Center-Joliet

0036798

Report Period Beginning: 07/01/1999

Ending:

06/30/2000

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2000 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 226,600	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 71,000)	1,231,605		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	12,616		6
7	Other Prepaid Expenses	5,111		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Deferred Income Tax Benefit	25,000		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,500,932	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	77,418		15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)	(23,435)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 53,983	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,554,915	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 283,637	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	265,366		29
30	Accrued Salaries Payable	201,266		30
31	Accrued Taxes Payable (excluding real estate taxes)	20,255		31
32	Accrued Real Estate Taxes(Sch.IX-B)	86,200		32
33	Accrued Interest Payable	54,205		33
34	Deferred Compensation			34
35	Federal and State Income Taxes	50,000		35
	Other Current Liabilities(specify):			
36	Accrued Management Fees	521,225		36
37	Accrued Rent	51,562		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,533,716	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,533,716	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 21,199	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,554,915	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 10,538	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 10,538	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	354,361	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(343,700)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 10,661	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 21,199	24 *

* This must agree with page 17, line 47.

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STATE OF ILLINOIS

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Facility Name & ID Number Rosewood Care Center-Joliet

0036798

Report Period Beginning: 07/01/1999

Ending:

06/30/2000

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 7,576,639	1
2	Discounts and Allowances for all Levels	(2,808,881)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,767,758	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,826,480	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,826,480	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	19,664	13
14	Non-Patient Meals	5,144	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 24,808	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	32,970	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 32,970	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Lab Discount	321	28
28a	Miscellaneous Income	2,128	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,449	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,654,465	30

2			
Expenses		Amount	
A. Operating Expenses			
31	General Services	\$ 787,025	31
32	Health Care	2,984,146	32
33	General Administration	1,524,883	33
B. Capital Expense			
34	Ownership	1,501,066	34
C. Ancillary Expense			
35	Special Cost Centers	214,104	35
36	Provider Participation Fee	65,880	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,077,104	40
41	Income before Income Taxes (line 30 minus line 40)**	577,361	41
42	Income Taxes	(223,000)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 354,361	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

**** Provide a detailed breakdown of "Other Revenue" on an attached sheet.

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